STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004017	A. BUILDING: _____ B. WING _____	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTINA HOUSE	1435 CHRISTIAN BLVD FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: December 17, 18 & 19, 2013. Facility number: 004017 Provider number: 004017 Survey team: Marcy Smith, RN-TC Patti Allen, BS Census bed type: Residential: 60 Total: 60 Census payor type: Other: 60 Total: 60 Sample: 7 Christina House was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey. Quality Review 12/19/13 by Lisa McColly	R 000		